Table of Contents

Dental Expense Benefits

The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan.

The following dental expense benefits will apply to you only if you have elected such coverage by returning your signed form in accordance with the enrollment procedures of this Plan.

This section explains the main features of the Plan. It is not complete without the corresponding "Summary of Coverage."

Booklet Base: Dental
Issue Date: January 1, 2000
Effective Date: January 1, 2000

Dental Expense Coverage

Dental Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for dental expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Comprehensive Dental Expense Coverage

Comprehensive Dental Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all dental care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

This Plan pays benefits for charges for dental services and supplies incurred for treatment of a dental disease or injury. These benefits apply separately to each covered person.

Calendar Year Maximum Benefit

This Plan has a Calendar Year Maximum Benefit. That is the most that is payable for all dental expenses incurred by a person in a calendar year. **It applies even if there is a break in coverage.**

Advance Claim Review

Be sure to read this section carefully.

Before starting a course of treatment for which **dentists'** charges are expected to be $ 200 or more, it is strongly recommended that details of the proposed course of treatment and charges to be made be filed in acceptable form with Aetna. Your Employer has the proper forms. Aetna will then estimate the benefits. You and the **dentist** will be told what they are before treatment starts. An Advance Claim Review is not required, but it is beneficial to you because it will let you know in advance how much the Plan will pay for your treatment.

A course of treatment is a planned program of one or more services or supplies to treat a dental condition. The condition must be diagnosed by the attending **dentist** as a result of an oral exam. The treatment may be given by one or more **dentists**. The course of treatment starts on the date a **dentist** first gives a service to correct or treat such dental condition.

Benefits

This Plan pays a benefit for Covered Dental Expenses equal to the Payment Percentage:

- of Type A expenses; and
- of Type B expenses; and
- of Type C expenses.

Covered Dental Expenses

Certain dental expenses are covered. These are the **dentists'** charges for the services and supplies listed below which, for the condition being treated, are:

- **reasonable** and **necessary**; and
- customarily used nationwide; and
- deemed by the profession to be appropriate. They must meet broadly accepted national standards of dental practice.

The Dental Expenses listed below will not be included as Covered Dental Expenses if they are covered in whole or in part:

- elsewhere under this Plan; or
- under any other plan of group coverage provided by or through your Employer.

Alternate Treatment

If alternate services or supplies may be used to treat a dental condition, Covered Dental Expenses will be limited to those services and supplies which:

- are customarily used nationwide for treatment; and
- are deemed by the profession to be appropriate for treatment. They must meet broadly accepted national standards of dental practice. The person's total current oral condition will be taken into account.

The Limitations section has some examples of how this works.

Type A Expenses

These expenses are not subject to the Dental Calendar Year Deductible

- Oral exams twice per calendar year. This includes prophylaxis, scaling and cleaning of teeth.
- Topical application of sodium or stannous fluoride for persons under 15 years of age.
- X-rays for diagnosis. Also other x-rays not to exceed one full mouth series in a 36 month period and one set of bitewings in a 6 month period.
- Dental sealants of the permanent bicuspids and molars for persons under 18 years of age, not to exceed one sealant per tooth in any three year period.

Type B Expenses

- Space maintainers for persons under 19 years of age.
- Oral surgery.
- Extractions.
- Fillings (except gold fillings).
- General anesthetics given in connection with covered dental services.
- Treatment of diseased periodontal structures.
- Endodontic treatment. This includes root canal therapy.
- Injection of antibiotic drugs.
- Repair or recementing of crowns, inlays, bridgework or dentures.
- Relining of dentures. This service is covered at 36 month intervals. Separate intervals apply for upper and lower dentures.
- First installation of removable dentures to replace one or more natural teeth extracted while the person is covered. This includes adjustments for the 6 month period following the date they were installed.
- Replacement of an existing removable denture or fixed bridgework by a new denture, or the adding of teeth to a partial removable denture. But, the "Prosthesis Replacement Rule" below must be met.

Type C Expenses

- Inlays, gold fillings, or crowns. This includes precision attachments for dentures.
- First installation of fixed bridgework to replace one or more natural teeth extracted while the person is covered. This includes inlays and crowns as abutments.
- Replacement of an existing removable denture or fixed bridgework by new fixed bridgework, or the adding of teeth to existing fixed bridgework. But, the "Prosthesis Replacement Rule" below must be met.

The following services and supplies required for treatment of temporomandibular joint dysfunction or myofascial pain dysfunction:

- Diagnostic oral examinations and x-rays.
- Restorative procedures to alter occlusion.
- Auto repositioning appliances.
- Joint manipulation and other physical therapy involving structures of the jaw.

The aggregate benefit payable for all treatment of temporomandibular joint dysfunction or myofascial pain dysfunction rendered to a dependent during his life will not exceed the Temporomandibular Joint Dysfunction/Myofascial Pain Dysfunction (TMJ) Lifetime Maximum regardless of any interruption in coverage.

Prosthesis Replacement Rule
Certain replacements or additions to existing dentures or bridgework will be covered under this Plan. But proof satisfactory to Aetna must be given that:

- The replacement or addition of teeth is required to replace teeth extracted after the present denture or bridgework was installed. The person must have been covered when the tooth was extracted.
- The present denture or bridgework cannot be made serviceable. Also, it must be at least 5 years old.
- The present denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered and cannot be made permanent. Replacement by a permanent denture is needed. It takes place within 12 months from the date the immediate temporary one was first installed.

Special Provisions For Orthodontic Treatments

A **dentist's** charges for services and supplies for **Orthodontic Treatment** are included as Covered Dental Expenses. In addition to all other terms of this dental benefit:

- The benefit rate will be the Payment Percentage for Orthodontic Treatment.
- Benefits will not exceed the Orthodontic Maximum for all expenses incurred by a family member in his or her lifetime. (It applies even if there is a break in coverage.)

Explanation of Some Important Plan Provisions

Calendar Year Deductible

This is the amount of Covered Dental Expenses you pay each calendar year before benefits are payable. There is a separate Calendar Year Deductible for each person.

Family Deductible Limit

If Covered Dental Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Limitations

When the Alternate Treatment part of this Plan applies, benefits will be limited. Some examples of how this works follow.

Restorative

Gold, Baked Porcelain, Crowns, and Jackets. Covered Dental Expenses will be limited to the charges for the procedure using amalgam or like material, if it would restore a tooth. This limit applies even if you and the **dentist** choose some other type of restoration.

Reconstruction. Covered Dental Expenses will be limited to the charges for the procedure needed to eliminate oral disease and replace missing teeth. Appliances or restorations needed to increase vertical dimension or restore the occlusion are deemed to be optional. They are not covered.

Prosthodontics

Partial dentures. Covered Dental Expenses will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. This limit applies even if you and the **dentist** choose a more elaborate or precision appliance.

Complete dentures. Covered Dental Expenses will be limited to the charges for a standard procedure. This limit applies even if you and the **dentist** choose personalized or specialized treatment.

Replacement of existing dentures. This will be covered only if the existing denture cannot be used or repaired. If it can be used or repaired, Covered Dental Expenses will be limited to the charges for the services needed to make the denture usable.

Exclusions

Covered Dental Expenses do not include and no benefits are payable for charges for:

- Treatment by other than a **dentist**. But the Plan will cover some treatments by a licensed dental hygienist that are supervised by a **dentist**. These are scaling of teeth, cleaning of teeth and topical application of fluoride.
- Services or supplies that are cosmetic in nature. This includes charges for personalization or characterization of dentures.
- The replacement of a prosthetic device that is lost, missing or stolen.
- Any services or supplies which are for orthodontic treatment, except as specifically provided.
- Services or supplies to increase vertical dimension. These are dentures, crowns, inlays and onlays, bridgework or any other appliance or service.
- Any services or supplies which are for treatment of temporomandibular joint dysfunction or myofascial pain dysfunction except as specifically provided under Type C Expenses.

Benefits After Termination of Coverage

This section applies to a person whose coverage ceases while not "totally disabled".

The term "totally disabled" means that due to injury or disease:

- You are not able to engage in your customary occupation and are not working for pay or profit.
- Your dependent is not able to engage in most of the normal activities of a person of like age and sex in good health.

Expenses incurred for the following after the person's coverage ceases under this benefit section will be deemed to be incurred when ordered:

- Dentures.
- Fixed bridgework.
- Crowns.

This applies only if the item is finally installed or delivered no more than 60 days after coverage ends.

"Ordered" means:

- impressions have been taken from which the dentures, crowns, or fixed bridgework will be made; and
- as to fixed bridgework and crowns; the teeth must have been fully prepared if:

  they will serve as retainers or support; or

  they are being restored.

General Exclusions

General Exclusions Applicable to Dental Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

  there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or

  if required by the FDA, approval has not been granted for marketing; or

  a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or

  the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is dental coverage.
- Those that a covered person is not legally obliged to pay.
- Those for services and supplies:

  Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.

  Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons.

- Those for acupuncture therapy. Not excluded is acupuncture when it is performed by a **physician** as a form of anesthesia in connection with surgery that is covered under this Plan.
- Those to the extent they are not **reasonable charges**, as determined by Aetna.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have group health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer are determined before those of a plan which covered the other parent for a shorter period of time.

   If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the

health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.

b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.

c. If there is not such a court decree:

If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.

If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

The benefits of a plan which covers the person on whose expenses claim is based as a:

- laid-off or retired employee; or
- the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses incurred in a calendar year will be reduced by all "other plan" benefits payable for those expenses. When the coordination of benefits rules of this Plan and an "other plan" both agree that this Plan determines its benefits before such other plan, the benefits of the other plan will be ignored in applying the general rule above to the claim involved.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during a calendar year, each benefit that would be payable in the absence of this provision will be reduced proportionately. Such reduced amount will be charged against any applicable benefit limit of this Plan.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

Effect of Medicare

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:

  having refused it;

  having dropped it;

  having failed to make proper request for it.

These are the changes:

- All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are figured.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When employment ceases. Ceasing active work will be deemed to be cessation of employment.
- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your employment ceases for the purposes of termination of coverage under this Plan. This date will be either the date you cease active work or the day before the next premium due date following the date you cease active work. Your Employer will use the same rule for all employees.

If you cease active work, ask your Employer if any coverage can be continued.

Dependents Coverage Only

A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee.
- When such person is no longer a defined dependent.
- When your coverage terminates.

Continuation of Coverage For Surviving Dependents

If you die as an active employee covered under any part of this Plan, and had completed more than 90 days of participation in the Department of Defense Nonappropriated Fund Health Benefits Program Dental Plan, and if your dependents are enrolled as a dependent in the Plan on the day preceding your death, any Dental Expense Coverage then in force for your dependents will be continued at no cost to them for the first four months following your death.

If at the time of your death you had completed more than 90 days, but less than 15 years of participation in the Department of Defense Nonappropriated Fund Health Benefits Program Dental Plan, any dependent's coverage, including coverage for your spouse, will cease at the end of the four month period right after your death.

If at the time of your death you had completed 15 or more years of participation in the Department of Defense Nonappropriated Fund Health Benefits Program Dental Plan, and were participating in an applicable defined benefit retirement plan, surviving dependents will be required to make contributions toward the cost of their coverage equal to the contributions then being charged to active employees for like coverage. Dependents acquired by your surviving spouse upon remarriage are precluded from coverage.

Under the above sections, any dependents' coverage (other than coverage for your spouse) will cease when any one of the following happens:

- A dependent ceases to be a defined dependent.
- A dependent becomes eligible for like coverage under this Plan.

If Dental Expense Coverage is being continued for your dependents, your child born after your death will also be covered. The completed enrollment form must be returned to your Human Resources Manager within 31 days of the date the child is born.

Proof of claim may be given by your spouse or by the custodial guardian of a minor child. Benefits will be paid to the person providing the proof.

Children With Disabilities

Dental Expense Coverage for your fully handicapped child may be continued past the maximum age for a dependent child if the child has not been issued a personal medical conversion policy.

Your child is fully handicapped if:

- he or she is not able to earn his or her own living because of mental retardation or a physical handicap which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully handicapped must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age.

Coverage will cease on the first to occur of:

- Cessation of the handicap.
- Failure to give proof that the handicap continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

Aetna will have the right to require proof of the continuation of the handicap. Aetna also has the right to examine your child as often as needed while the handicap continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age.

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Aetna will not try to reduce or deny a benefit payment on the grounds that a condition existed before a person's coverage went into effect, if the loss occurs more than 2 years from the date coverage commenced. This will not apply to conditions excluded from coverage on the date of the loss.

Assignments

Coverage may be assigned only with the written consent of Aetna.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the expense. You may obtain claim forms through your Employer or through Aetna Member Services.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 2 years after the deadline.

Payment of Benefits

Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you. However, this Plan has the right to pay any health benefits to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.

This Plan may pay up to $ 1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when claim is made.

Very important are:

Names of **dentists** who furnish services.
Dates expenses are incurred.
Copies of all bills and receipts.

Additional Provisions

The following additional provisions apply to your coverage.

- You cannot receive multiple coverage under this Plan because you are connected with more than one Employer.
- In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. Additional provisions are described elsewhere in the Plan Document on file with your Employer. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued as to all or any class of employees.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Dentist

This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Necessary

A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her family, any healthcare provider or healthcare facility; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Non-Occupational Disease

A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury

A non-occupational injury is an accidental bodily injury that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Orthodontic Treatment

This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Parent-Child Relationship

A parent-child relationship exists between you and a child when the child is primarily dependent on you for support and the child is:

- unmarried;
- resides in the same household as you;
- has not reached the limiting age of the plan; and
- if school age and regularly attending school, resides primarily in your home.

When a natural parent lives in the same household, a parent-child relationship exists between you and a child only when both the natural parent and the child are primarily dependent upon you for support and the natural parent as well as the child meet the IRS dependency tests.

Physician

This means a legally qualified physician.

Reasonable Charge

Only that part of a charge which is reasonable is covered. The reasonable charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and

- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the prevailing charge level made for it in the geographic area where it is furnished.

In determining the reasonable charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the prevailing charge in other areas.

Student

A student is one who;

- attends school regularly on a full-time basis;
- is not employed full-time (working 7-8 hours a day, 5 days a week); and
- attends a school which:

  is an institution which offers a regular schedule of courses on an annual or more frequent basis;

  has a full-time faculty and a permanent administration; and

  includes some formal classroom sessions rather than just on-the-job training.